STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX **File No. 77243-001**
Petitioner
v

Golden Rule Insurance Company
Respondent
_____/

Issued and entered
this 13th day of November 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On October 2, 2007, XXXXX, authorized representative for minor child XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the information and accepted the request on October 4, 2007.

The Commissioner notified Golden Rule Insurance Company of the external review and requested the information used in making its adverse determination. American Medical Security, an affiliate of Golden Rule, provided the information and documents on September 28, 2007.

The issue here can be decided by applying the terms of the certificate of coverage, the contract defining the Petitioner's health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner has health care coverage under a Golden Rule group policy. The Petitioner suffered a severe brachial plexus injury at birth causing severe contractures of the arm and chest. Reconstructive microsurgery was performed on November 5, 2005 by Dr. XXXXX at the XXXXX.

The Petitioner's mother received preauthorization from Golden Rule on October 12, 2005 for the Petitioner's surgery. Claims for services were submitted to Golden Rule. Golden Rule paid the claims at the preferred provider benefit level based on reasonable and customary charges as defined in the Petitioner's certificate of coverage. The Petitioner appealed.

Golden Rule reviewed the claims but upheld its determination. A final adverse determination was sent to the Petitioner September 21, 2007. The Petitioner is now being billed for charges totaling $44,950.62.

III
ISSUE

Is Golden Rule required to pay more for the Petitioner's surgery at XXXXX on November 3, 2005?

IV
ANALYSIS

Petitioner's Argument

The Petitioner's family obtained preauthorization from Golden Rule for the surgical procedure. They were aware that reasonable and customary charges would apply but expected those charges to be much higher due to the unique and specialized surgery involved.

The Petitioner's authorized representative states that the fees charged by the surgeon performing the procedure were reasonable and appropriate and not susceptible to standard billing codes.

The Petitioner believes Golden Rule should accept Dr. XXXXX fees as reasonable and customary affording full coverage for the surgical procedure.

Golden Rule Insurance Company's Argument

On October 12, 2005 Golden Rule approved the Petitioner's proposed surgery subject to the terms and conditions of the Petitioner's plan with benefits limited to the reasonable and customary charges. The Preferred Provider Benefit Rider in the Petitioner's plan states: "if a covered person incurs covered expenses for services or supplies which are not of the type provided at any preferred provider, these covered expenses will be treated as if they had been incurred at a preferred provider." Golden Rule states all claims were processed at the Preferred Provider level of benefits.

Reasonable and Customary Charges are explained as follows in the Definitions Section of the Petitioner's Policy:

> **"Reasonable and customary charges"** means with respect to fees charged by a medical practitioner or by a supplier of professional services, medicines or supplies, the most common charge for similar professional services, medicines, or supplies within the area in which the charge is incurred, so long as those charges are reasonable. Reasonable and customary charges will be determined by us.
>
> The amount which would be at least as much as the amounts charged by two-thirds of the providers within the area in which the charge is incurred will be considered the most common charge. "Area" means: (A) the three digit zip code in which the service or supply is provided; or (B) a greater area if necessary to obtain a representative cross section of charges for a like service or supply.

Under **General Exclusions and Limitations** the policy states:

> **EXCLUSION ON CHARGES IN EXCESS OF REASONABLE AND CUSTOMARY:**
> If a charge incurred by a covered person for services or supplies is in excess of the reasonable and customary charge, no payment will be made with respect to the excess amount of the charge. That part of the charge which is in excess of the reasonable and customary charge will not qualify as a covered expense under the policy.

In the original processing of the claim Golden Rule states they covered $11,246.00 of the

$58,980.00 charged. An external medical consultant and neurosurgeon reviewed the claims and determined reasonable and customary charges to be $7,349.00 and $7,359.00 respectively. Golden Rule says since their original processing allowed more, additional benefits were not available.

Golden Rule asserts the charges were appropriately considered and reaffirm their original benefit determination.

Commissioner's Review

The Commissioner has considered the arguments and documentation of both parties as well as the certificate of coverage. The Commissioner understands the Petitioner's parents' unhappiness that she has incurred significantly higher out-of-pocket costs than anticipated.

The Petitioner's plan covered non-preferred provider services at the preferred provider level of benefits. Non-preferred providers are not in the network of providers contracted with Golden Rule and therefore, the insured can expect to have higher out-of-pocket expenses. The plan provides benefits for covered charges to the non-preferred provider to the extent that the service doesn't exceed the reasonable and customary charge for that service.

The Petitioner's policy clearly states "If a charge incurred by a covered person for services or supplies is in excess of the reasonable and customary charge, no payment will be made with respect to the excess amount of the charge." Golden Rule's determination of "reasonable and customary" charges is based on the geographical area where the services are provided. Specific amounts are determined by a company that specializes in collecting medical charge data.

The Petitioner's authorized representative objects to the covered amount calculated in this way. The Commissioner, in deciding this case, is bound by the terms and conditions of the Petitioner's health care policy. Specific reimbursement rates are not regulated by the Office of Financial and Insurance Services or any state agency and are therefore beyond the regulatory authority established by the Patient's Right to Independent Review Act.

It is regrettable the Petitioner's mother did not anticipate the extent of her responsibility for charges from a non-preferred provider. However, the Commissioner finds that Golden Rule paid the Petitioner's claims according to the terms and conditions of coverage.

V
ORDER

The Commissioner upholds Golden Rules adverse determination of September 21, 2007. Golden Rule is not required to pay more for the Petitioner's surgery on November 3, 2007

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.